GPRA INDICATORS; 2003
Indian Health Service

Substance Abuse Treatment Group:

These two indicators address substance abuse treatment. The first targets the reduction of relapse rates by improved aftercare for youths completing residential treatment programs. The second addresses identification and referral of pregnant woman at risk for alcohol related birth defects.

Indicator 9: During FY 2003, Regional Treatment Centers will collectively achieve at least a 5% increase over the FY 2002 baseline for each of the following criteria:

a. % of youths who successfully completed alcohol/ substance abuse treatment at IHS funded Residential Youth Treatment Centers
b. % of youth (that completed treatment) who developed an aftercare plan with their appropriate aftercare agency
c. % of youth who have this after care plan communicated to the responsible follow-up agency; documentation of this communication must be in the youth RTC record
d. % of RTC programs that have a family week opportunity for youth that participate in the Regional Treatment Centers

Rationale: This indicator is intended to evaluate outpatient substance abuse resources for youth. Outpatient community resources specific to the youth population are an essential part of the continuum of behavioral health care services. The majority of our youth do not participate in inpatient treatment centers.. However, if available, successful completion of residential treatment can help reduce drug and alcohol use relapse in youths .

Family involvement in treatment is predictive of treatment outcome. (Stewart 1993; Hsieh, 1998). Opportunities for and participation by families in a residential family week are predictive of long term improving teens. Residential Treatment Centers need to ensure that family week opportunities exist.

Studies indicate that the longer individuals are engaged in treatment (including aftercare/continuing care) the better the prognosis (Hoffmann, DeHart, & Gogineni, 1998; Zywiak, Hoffmann, & Floyd, 1999). Aftercare is usually provided in the referring community. There has historically been limited coordination among RTCs, service units and local aftercare programs. The aftercare measure aims to assure the coordination of effective and efficient delivery of follow-up treatment services at the local level following RTC release. Aftercare or continuing care is, ultimately, the responsibility of the referring community of residence of youth who were treated in a residential facility.

Approach: The Division of Clinical and Preventive Services, Office of Public Health will be responsible for coordinating data collection from the area behavioral health coordinators. The Behavioral Health component (Alcoholism and Substance Abuse Program) continues to assist in the development of an ongoing evaluation instrument in consultation with the RTCs. In addition, the RTC's utilizing the RPMS Chemical Dependency Management Information System (CDMIS) and the RPMS Mental Health/Social Service (MH/SS) packages routinely collect information that can be exported for national reporting purposes. These packages are currently being rewritten with a planned distribution for FY 03.

The process of collecting YRTC data is becoming more complex due to tribal sovergnity and the use of non-federal commercial software management information software packages. Efforts to improve reporting by local tribally managed programs will continue to be encouraged with a goal of national data compatibility .

Findings from the Comprehensive Assessment & Treatment Outcome Research adolescent study indicate that youth engaged in aftercare/follow up activities had better sobriety rates than those who did not, but for optimal benefit, contact frequency of at least twice per week was required (Hoffmann, Mee-Lee, & Arrowood, 1993). The majority of aftercare services are the responsibility of local programs as youth who have completed YRTC treatment return to their community for aftercare services. Data suggest that youth whom have completed treatment and are involved in continuing care and follow-up services maintain higher sobriety rates. YRTC's must ensure that adequate aftercare treatment plans are developed and communicated to the appropriate aftercare agency . The majority of aftercare is not done with through the YRTC. Consequently, it is difficult to track 6 month outcome data. Due to ongoing problems with this data, long term outcome data is not included in FY 2003. Other proxy measures predictive of long term residential treatment success have been substituted.

Data Source: **Data for this indicator are collected from the area Behavioral Health coordinators, as well as RPMS applications, the RTC evaluation system, and other software utilized by the RTCs and provided to the Areas and Headquarters. Both Area and Headquarters behavioral health staff review the data for completeness and have frequent dialogues with each other or directly with the RTC s to resolve identified data problems. These different sources of data are then analyzed and compiled into one report at Headquarters. Efforts to standardize the RTC data collection format for all RTCs and Areas is a priority during FY 2002; FY 2003 will focus on the data verification and validation process. In addition, we are hopeful that the new behavioral health RPMS application will support additional outcome indicators.**

Type of Indicator: Process/Impact and Balance Scorecard: internal perspective

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the Illicit Use of Drugs*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services*. This indicator also directly supports HP 2010 objective 26-10 (Substance Abuse: reduce youth use of illicit substances).

Program Performance: **The FY 2001 performance measure was to provide follow-up equal to or greater than the FY 2000 level and to increase at least by 5% over the FY 2000 level the percentage of youths who have documented 6 months of less alcohol and drug use than before treatment. 12 YRTC's reported data in FY 2001, which is similar to FY 2000.**

This target was accomplished in FY 2001 with 60.0% of the youths discharged from RTC receiving follow-up contacts at 30 days, at least a second follow-up by 6 months, and at least a third at 12 months after discharge This compares to 48.0% in FY 2000, which represented a 12% increase in follow-up.

There continues to be an ongoing issue of data collection, analysis and compilation. Half of the YRTC facilities utilize RPMS and the others utilize other data software systems. Transparent data extraction from different data sources to the national IHS data center still needs improvement. The proposed integrated behavioral health RPMS clinical application should solve many of these needs.

Indicator 10: During FY 2003, maintain the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women at the FY 2002 level.

Rationale: **The purpose of this indicator is to contribute to systematic efforts at reducing the incidence of Fetal Alcohol Syndrome (FAS). Surveillance conducted at two IHS Areas indicated FAS rates greatly exceed general population rates (2.3**

and 2.7/1000 live births vs. 0.6/1000 live births approximately). The Institute of Medicine 1996 report on FAS includes case identification and appropriate intervention and treatment of a maternal alcohol abuse as a critical part of FAS prevention. Thus, the purpose of this indicator is to assure that providers consistently screen and make appropriate referrals for women at risk. The written protocol makes this more likely because these efforts become part of the local quality assurance process. However, successful implementation of such a process requires staff training as well as cooperation from tribes and local governing bodies and thus requires resources and time.

Approach: **The I/T/Us will be responsible for reporting via survey to be conducted by the Division of Clinical and Prevention Services, Office of Public Health relative to the implementation of protocols. Resources for analysis may be required from other divisions within the Office of Public Health. The Prenatal Health Assessment (PHA) screening instrument was developed in the Aberdeen IHS Area with the Centers for Disease Control and Prevention. A curriculum for utilizing the instrument in prenatal clinics and developing case management systems has been piloted in that Area in FY 1998. In the Aberdeen Area, there are numerous clinics and hospitals that are currently using the protocols. In FY 1999 the protocols will be piloted in two new Areas. This screening instrument is one of several recognized protocols that are being encouraged for use in I/T/U programs to assure the routine prenatal substance abuse screening and case management tailored to the resources of each site.**

Data Source: **Survey and possibly RPMS**

Type of Indicator: **Process and Balance Scorecard: internal perspective**

Linkages: **This indicator supports the DHHS Strategic Plan, Strategic Objectives 1.4 *Curb Alcohol Abuse*, 1.5 *Reduce the Illicit Use of Drugs*, 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives,* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services.* This indicator also directly supports several HP 2010 objective 16-16 (Maternal, Infant, and Child Health: Fetal Alcohol Syndrome).**

Program Performance: **The FY 2001 indicator committed to increasing the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 10% over the FY 2000 level which was 87.6% based on 12 Areas reporting . For FY 2001, all 12 Areas reported for a total of 226 prenatal clinics. Of those, 216 had implemented such protocols for a rate of 94.7%, which is a 7.1% improvement over FY 2000 but did not reach the 10% target increase. I retrospect the target should have been adjusted down with the accomplished the 11.7% increase in FY 2000, hence leaving little room for improvement. Looking longer term, the combined two-year target increase of 15% was exceeded with an actual total increase of 16.3% increase.**

Family Violence, Abuse, or Neglect Indicator:

Indicator 15: During FY 2003 the IHS will address domestic violence, abuse, and neglect by assuring that:

a. at least 85% of I/T/U medical facilities (providing ER and urgent care) will have written policies and procedures for routinely identifying and following:
    - intimate partner abuse (IPV)
    - child abuse and/ or neglect
    - elder abuse and/ or neglect
b. at least 50% of I/T/U medical facilities (providing direct patient care) will provide training to the direct clinical staff on the application of these policies and procedures
c. a standard data code set is developed for the screening of intimate partner abuse in conjunction with the Family Violence Prevention Fund and AHRQ

Rationale: **This indicator is designed to help ascertain, evaluate and reduce the prevalence of family violence, abuse and neglect in AI/AN communities. The umbrella of family violence includes child, intimate partner, or elder abuse/ neglect. These victims of violence and neglect enter the health care system with a myriad number of physical injuries, illnesses or medical conditions related to this abuse. Known consequences of family violence include decreased health status, as evidenced by the development or exacerbation of multiple medical conditions, depression, suicide and/or homicide.**

There is a lack of reliable data on the incidence and prevalence of IPV among AI/AN populations. MMWR recently published the results of a surveillance of homicide among intimate partners in the US (1981-1998). This data indicated that age adjusted annual rates for intimate partner homicide were double for AI/AN people compared to whites, and 1 ½ times greater than US all races. (MMWR)

Victims of IPV can benefit from appropriate office intervention and referral. However, implementation of screening guidelines for IPV has been challenging in most clinical settings. A multifaceted 'systems' approach is needed to provide an effective means to improve domestic violence screening, as well as identification and intervention in health care settings. This approach must begin with the establishment of appropriate tools for domestic violence evaluation, referral and reporting. Managed care organizations have successfully shown improved domestic violence services and improved health plan members experiences through this systems approach. (2)

IHS believes that the first step in this multifaceted systems approach is contingent upon the development and implementation of appropriate policies and procedures. This indicator will assure that policies and procedures that identify violence, abuse and neglect will be developed at local facilities. Successful implementation of the process depends upon staff training as well as cooperation from tribes and local governing bodies.

Approach: **The IHS will work with Area Offices to assure that appropriate local policies and procedures are developed and that staff members are trained in these protocols. Policies and procedures are available for download via the IHS Internet.**

In addition, IHS will work with the Family Violence Prevention Fund to develop training materials that are specific for AI/AN communities. This training material will be distributed to I/T/U medical facilities.

IHS also plans to enter into a collaborative agreement with the Family Violence Prevention Fund as well as DHHS. This agreement will be designed to facilitate the development of our teaching materials. In addition, this agreement will facilitate the implementation and evaluation of a multifaceted systems approach at pilot sites throughout AI/AN communities.

Finally, we will work to develop a standard code for intimate partner violence screening that can be recorded and retrieved using our RPMS database. This will enable us to track, for the first time, our screening efforts for intimate partner violence.

Data Source: **Annual surveys and/ or progress reviews by IHS Area and Headquarters Staff. Baseline data on screening will be based upon a query of 2001 data from RPMS. The lack of an official CPT code for screening significantly hinders our ability**

to retrieve reliable screening data at this time. Once a standard code has been developed, these codes will be adopted and distributed throughout the I/T/U facilities. These codes will used to categorize and retrieve intimate partner violence data.

Type of Indicator: **Process and Balance Scorecard; internal perspective**

Linkages: **This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4** ***Improve the Safety and Security of Children and Youth,*** **3.2** ***Increase the Availability of Primary Health Services*****, 3.6** ***Improve the Health Status of American Indians and Alaska Natives,*** **and 4.2** ***Reduce Disparities in the Receipt of Quality Health Care Services.*** **This indicator also addresses several HP 2010 objectives in Focus Area 15: Injury and Violence Prevention.**

Program Performance: **The FY 2001 indicator was to assure that at least 75% of I/T/U medical facilities with urgent care or emergency departments or services have written policies and procedures for routinely identifying, treating, and/or referring victims of domestic violence, abuse or neglect as well as child abuse/ neglect and elder abuse/ neglect. Performance on this indicator in FY2001 was assessed through a survey that was distributed to the Area Offices. The Area Offices then forwarded the survey to their I/T/U facilities. The Area GPRA coordinators collected the responses, and forwarded these to the National Program. This year, the survey was NOT distributed to any sites that did not report ER or urgent care services.**

In 2000, a more detailed survey indicated an aggregate compliance rate of 72% for policies and procedures. The current rates for FY 2001, based on 97 sites reporting, are as follows:

a. **intimate partner/ spousal abuse – 83%**
b. **child abuse/ neglect – 82%**
c. **elder abuse/ neglect – 84%**

Averaging these three categories gives an aggregate rate of 83%. The IHS met this indicator, both individually and in aggregate. The following changes were implemented this year for this indicator:

a. **the survey was distributed to the area GPRA coordinators, who were responsible for ensuring that the information was collected in a reasonable time period**
b. **more accurate information—due to # 1, only appropriate sites participated in the survey (as determined by the area coordinators); the denominator for FY01 is less than for FY00. For instance, the California area facilities do not provide ER or urgent care, so were excluded this year (based upon their decision)**
c. **prototypes and policies—the IHS Women's Web site was established, and has domestic violence/ intimate partner violence policies and procedures available in a downloadable format**

Indicator 17: During FY 2003, improve the Behavioral Health Data System by:

a. Assuring at least 50% of the I/T/U programs will report minimum agreed-to behavioral health-related data into the national data warehouse.
b. Increasing the number of I/T/U programs utilizing the RPMS behavioral health data reporting systems by 5% over the FY 2002 rate.

Rationale: **The purpose of this indicator is to improve the behavioral health status of AI/AN people. This indicator will help document the agency's ability to improve BH data collection and reporting by offering enhanced and better tools. Better BH data collection and analysis will improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs.**

Audits of the existing I/T/U data systems have documented both lack of reporting and under-reporting of behavioral health related conditions (i.e. depression, alcohol, drug, substance abuse, etc.) and services provided. Improved data collection systems and secondary reporting will provide better quality and more realistic baseline information. This will enhance and complement national, private, and public outcomes monitoring efforts. Improved data options will also support consistent reporting, data aggregation for planning, managed care, and more effective billing and collection for services. This indicator is also essential for monitoring many of the HP 2010 objectives addressing "Mental Health and Mental Disorders, Alcohol, Drug, and Substance Abuse Disorders".

Approach: **Improving behavioral health outcomes relies on two important activities: data collection as close to point of care as possible, and data reporting in a standardized way that can be understood across the Indian health system. Standardized data reporting can be achieved by providing a usable, provider-driven and provider friendly computerized application to I/T/U sites.**

A key activity beginning in FY02 is the design and implementation of an integrated Behavioral Health system. This system will provide a full range of functions for all aspects of behavioral health disciplines, i.e., social work, alcohol and substance abuse, psychology, psychiatry, regional treatment centers, etc. The Behavioral Health Design project will identify and document updated functional and technical requirements necessary for an integrated information management system to enhance patient identification and tracking, treatment plans, evaluation of services, and improve third party reimbursement. A multi-phased Interim Solution will address the need for incremental improvements in existing RPMS systems. A graphical user interface (GUI) will be applied to key functions of the existing RPMS systems, Mental Health/Social Services (MH/SS) and Chemical Dependency Management Information System (CDMIS). A GUI will address many existing concerns about ease of use and training, encourage new user, and make data standardization more likely.

Data reporting can also be improved by designing and implementing simplified and standardized data movement mechanisms from sites to the IHS national data repository.(data warehouse) Until recently, the I/T/Us were sending data to multiple sources in multiple formats, making it impossible to ensure the validity and accuracy of data. . The Data Quality Action Team (DQAT) initiative, begun in FY01, has been implementing standardized data movement as well as piloting a data warehouse design that is expected to be implemented at a national level during FY02. Behavioral health data will become a subset, or "data mart", within the overall data warehouse that will eventually be accessible with appropriate permissions for analysis, manipulation and report publishing.

Encouraging data reporting by I/T/Us will result in publishing data in a timely, accessible and useful way is necessary. The IHS Indian Health Performance Evaluation System (IHPES), a performance measurement system initially designed to satisfy Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hospital ORYX standards, has developed a national Mental Health SAS database (from all Mental Health data exported from the Indian Health Service MH/SS package to the national data center for analysis and reporting). The Behavioral Health MIS Workgroup currently is working with IHPES programmers to define and publish via the web a series of statistics. The usefulness of these reports will be improved in an iterative way; as data collection and data reporting increase, and the quality of data improves, these reports will become more accurate and therefore more useful.

Data Source:
a. Increased data reporting**: sites reporting behavioral health data can be obtained monthly from the Indian Health Performance Evaluation System (IHPES) Team maintaining the Mental Health SAS database (see above).**

b. Increased RPMS use**: Various behavioral health components of RPMS. Each year a survey with a preformatted spreadsheet is sent to all 12 I/T/U Area information system coordinators (ISCs) to complete and update as more programs come online with any behavioral health-related RPMS applications and other commercial BH packages as appropriate.**

Type of Indicator: **Process and Balance Scorecard: innovation and learning perspective**

Linkages: **This indicator supports the DHHS Strategic Plan, Strategic Objectives 2.4 *Improve the Safety and Security of Children and Youth*, 3.6 *Improve the Health Status of American Indians and Alaska Natives*, and 5.1 *Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to the Health of the Nation's Population.* This indicator also supports several HP 2010 objectives in Focus Area 18: Mental health and Mental Disorders.**

Program Performance: **The FY 2001 performance measure was to increase the percent of I/T/Us that have implemented the use of the MH/SS data reporting system by 10% over the FY 2000 level, which was 51.0%. This measure was achieved in FY 2001.**

Factors Relating to Performance: The FY 2001 totals for this indicator were taken directly from the national data center "actual" data that was exported and received from all I/T/Us programs by the national data center. This comparative data was based upon data sent to the national data base since 1990. The GPRA report for this indicator in FY 2000 was based upon programs self-reporting the use of this RPMS package, which did not necessarily mean these programs had been exporting data to the national data center.

In FY 2001, further efforts were made to refine the system and analyze data exported to the national data center. Analysis of "actual" sites exporting Mental Health data showed an increase of sites exporting data; a 46% increase in FY 1999, 24.7% increase in FY 2000 and 12.1% increase in FY 2001. If analyzed from 1990 when the system was initiated, a gradual increase in use and data exported from the system would be revealed. The current utilization of "actual" data imported into the national IHS data center by I/T/U is as follows: IHS facilities are exporting data at 72.55% of all Mental Health data, tribal programs at 23.53% and Urban programs at 3.92%.

A new version of the MH/SS MIS package, which combines relevant data items from the Chemical Dependency MIS and the MH/SS MIS was not tested and implemented in FY 2000, as had originally been planned. This package is scheduled to be evaluated and rewritten in FY 02 and FY 03, as noted in the following performance plan.

Performance Improvement Plan: Implementation of a phased approach to an integrated Behavioral Health software application, as described in the *Approach* section above, should help achieve this indicator. Phases will include: 1) providing a BH template containing minimum data fields that can be implemented either manually or electronically; 2) providing a GUI to RPMS for selected behavioral health functions to provide a more intuitive interface to encourage use of existing systems; 3) design an integrated application that incorporates all aspects of behavioral health, to include a GUI; 4) plan and implement a formal deployment and training plan. By demonstrating fairly quickly a more usable system, and promoting the benefits of using standardized data, we believe that sites will be more interested in using the revised RPMS application. Expanding the use of this system continues to be a crucial component of the overall Behavioral Health efforts throughout the IHS, including tribal and urban programs. Recently with the advent of tribal sovereignty and improvements in behavioral health management information systems, many tribal and urban programs are exercising "choice" in the selection of type of Behavioral Health Software utilized. Therefore, improving the overall data entry, collection and storage has increasingly become a significant task ; the IHS serves as a facilitator for overall improved behavioral health management information systems. The IHS through its Information Technology Support Center (ITSC) will be able to provide a warehouse to store national ITU Behavioral Health data that can then be accessed by the ITU system as needed.

Suicide Prevention Indicator:

Indicator 27: During FY 2003, increase by 5% over the FY 2002 level, the proportion of I/T/Us that have implemented systematic suicide surveillance and referral systems which include:

a. monitoring the incidence and prevalence rates of suicidal acts (attempts and completions)
b. assuring appropriate population-based prevention and interventions are available and services are made accessible to individuals identified at risk

Rationale: **This indicator is part of an expanding systematic effort at reducing the prevalence of suicide in the AI/AN population. The suicide death rate for the AI/AN population has actually increased in the 1990s and is currently 72% greater than the national average. This problem has been particularly devastating for a number of AI/AN communities that have experienced dramatic increases in adolescent suicides in recent years and represents one of the greatest tragedies the IHS must address. The implementation of local suicide surveillance and prevention projects has been successful in reducing suicide acts in several Indian communities. The obvious goal of diffusing intervention approaches and learning from successful programs to other AI/AN settings is to reduce suicide acts in the AI/AN population as quickly as possible.**

Approach: **The I/T/Us will be responsible for reporting the implementation of protocols to the national data center that will compile and analyze all reported data. A suicide surveillance and prevention system was developed in the Albuquerque IHS Area (National Suicide Prevention Project with the Center for Disease Control and Prevention). A suicide surveillance instrument that identifies potential high-risk individuals has been developed and is currently being used in clinics and case management systems have been piloted. Numerous clinics, hospitals and behavioral health programs are currently using suicide surveillance protocols and now simply need to be identified and counted. A suicide surveillance and prevention system is being encouraged for use in I/T/Us to assure the routine suicide screenings and case management are tailored to the needs and resources of each site**

Data Source: **Local programs will send reports to the national ITSC with identified data sources linked with RPMS as appropriate. Refinement of data source activity will remain with the 7 IHS Areas that are currently reporting data to the ITSC.**

Type of Indicator: **Impact and Balance Scorecard: internal perspective**

Linkages: **This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.2 *Increase the Availability of Primary Health Services*, 3.6 *Improve the Health Status of American Indians and Alaska Natives,* and 4.2 *Reduce Disparities in the Receipt of Quality Health Care Services.* This indicator also directly supports several HP 2010 objectives in Focus Area 18: Mental Health and Mental Disorders that address the incidence of suicide.**

Program Performance: **The 2001 indicator committed to reducing suicide rates by assuring that by the end of FY 2001, at least 50% of the I/T/U programs will have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented. The FY 2001 indicator was not met with only 28 I/T/U sites out of 227 (12%) that reported suicide data monitoring rates of ideation, attempts and completions in FY 2001.**

Reasons for not meeting the indicator include inability to establish uniform and compatible reporting systems among the I/T/U programs and inadequate support for technical assistance and equipment. Corrective action taken in FY 2001 was to establish priority for behavioral health data improvement. Provision of additional resources allowed many local behavioral health programs to obtain and upgrade data systems in FY 2001.

Other strategies to improve performance include the establishment of a national behavioral health data work group which will focus on completion and implementation of an integrated behavioral health MIS, establishment of a baseline of all reporting programs, assuring articulation among the different data systems and using the national Information Technology Support Center (ITSC) for support. The ITSC will facilitate and provide technical support to Areas for I/T/U system-wide improvement for data collection and analysis. The work of the workgroup in FY 2002 will provide additional information that may define a more appropriate suicide prevention indicator for FY 2003

2002 GPRA Indicators	Modifications for 2002	Modifications for 2003	Modifications for 2004	Reasons for change
Indicator # 9	No Change	• A is OK • change b/c to be percentage of clients for whom continuing care plan is developed and communicated with the continuing care program • D is OK, though add ' structured family involvement"	• referring agency needs to do primary care plan—consider doing this for 05, including an evaluation before going to treatment • consider adding additional indicator, including a modification to enhance what is being offered in 04.	
Indicator # 10	No Change	No Change	• percentage of women of child bearing age (12-45 y.o.) who receive an annual screen for alcohol use • plan is to use current HF field to record this data • will recommend some type of easy screen—perhaps T/CAGE (presently able to be recorded within the HF field) • other proposed changes for later years include tracking referrals to A/SA programs// number of BH FAS prevention sessions for female clients	
Indicator # 15	No Change	No Change	• Connie will propose change in indicator by April 20	Sent email to Connie, waiting for her changes. 4/23/02
Indicator # 17	No Change	• eliminate B, as we are designing a new program • leave A, but stop after data…. (do not talk about national data warehouse)	• increase reporting by 5%; leave rest the same as A	
Indicator # 27	No Change	• change surveillance to evaluation and referral	• change indicator to establish baseline on adolescent suicide attempts (less than 19 y.o.) • consider using areas where BH is in place –Phoenix, Albq, Aberdeen, Billings • Run logic to query multiple applications—PCC, BH, RCIS, etc	